# Flightfax

ARMY AVIATION RISK-MANAGEMENT INFORMATION

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Let's continue to meet this year's challenge head-on by remembering that risk management is everyone's responsibility. So far, it's making a difference and saving lives...

...and that's good news!

# Good News

There's good news from the Safety Center operations research systems analysts. A mid-year review of the Army Safety Program showed that Fiscal Year (FY) 2000 ground and aviation accident rates are lower than FY99 and the previous 3 years.

Relative to this time last year, we are seeing reductions in the number of accidents in nearly every category: Total aviation/ ground accidents, military fatalities, off-duty accidents, and privately owned vehicle (POV) accidents. These numbers are direct results of leaders integrating risk management into training and battlefield operations, as well as off-duty safety.

As of 31 March 2000, total aviation and ground Class A accidents are 10.1 percent lower than FY99, and equal to the three-year average. Total military fatalities are also reduced 7.5 percent from last year, but still are 1.4 percent higher than the 3-year average.

## Making a Difference

Leadership involvement at all levels is making a difference in integrating safety into operations and making risk management work. To continue this positive trend, we must maintain our focus on standards and discipline.

Effective crew coordination can mitigate the effects of design complexity and crew experience. Commanders must stress crew coordination and ensure integration and enforcement of the crew coordination program at unit level if we are to further reduce the aviation accident rate.

Relative to this time last year, the aviation rate for Class A and B accidents is 51 percent lower than the first quarter FY99 and the three-year average.

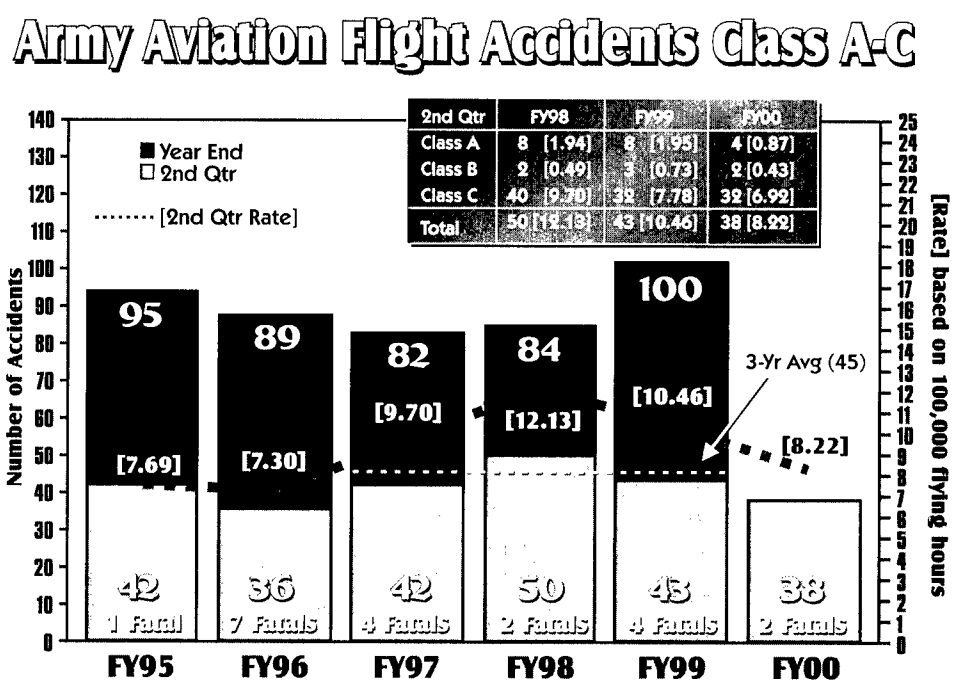
As we enter the summer months and prime training opportunities are capitalized upon throughout the Army, we can expect to see our exposure for mishaps increase. That, coupled with the fact that new personnel will arrive who will probably lack skills that are unique to your mission and environment, tends to also increase a unit's risk factors. Units can effectively manage these risk factors by integrating risk management into every phase of your training program. Such training programs are a direct result of a comprehensive evaluation of individual and collective skills that are required to execute the unit mission. Visibility and consideration of Armywide trends that were evident last FY, such as poor power-management techniques, must be kept in the forefront to ensure they are mitigated.

Recent analysis of Army aviation accidents has identified the following major risk factors in aviation operations:

1. Complex aircraft design
2. Lack of experience within Army aviation

As aviators, it is of vital importance that we remember the complexity of not only the aircraft we fly, but also the missions we find ourselves involved in daily. Routine missions are never "no-risk", and we must approach them with the same attention to detail that we do for our "high-risk" missions. We must not let complacency gain the upper hand.

Leadership involvement is making a positive impact on off-duty safety. POV accidents for FY00 are down 22.1 percent from the previous year and down 4.6 percent from the three-year average. Military fatalities from POV accidents are down 19 percent from FY99 and down 1.9 percent when compared to the three-year average.



Despite the progress we have made, some trends remain constant. The profile of our most at-risk soldiers remains the 19 to 24-year old males, E-2 through E-5. These young soldiers have yet to realize their mortality; they consistently underestimate their personal risk and are over-confident in their personal ability.

Individual discipline remains a factor in the severity of POV accidents. Twenty-three percent of soldiers killed in off-duty POV accidents during FY99 were not using seat belts or motorcycle helmets. Unfortunately, this trend continues.

## CHAIN TEACHING

The Chief of Staff, Army, has directed that every soldier be trained on risk management by 1 July 2000. The Safety Center has developed an excellent chain-teaching packet on compact disk that is available now for


commanders and small group leaders. Contact Dr. Brenda Miller, DSN 558-3553 (334-255-3553) or e-mail millerb@safetycenter.army.mil if you have not received your CD.

As we move into the "100-Plus Days of Summer", and the critical time of year when we normally suffer the greatest number of accidents, what can we do to ensure this positive mid-year trend continues?

As evidenced by the lower accident rates in FY00, leadership is making a difference and we must continue to emphasize leadership, standards and discipline. Leaders at all levels must be on the front lines to look for ways to break the chain of events that leads to an accident.

Our focus on discipline (seatbelt use, drinking and driving, complacency, violation of rules/standards) must continue and complement our emphasis on the proper application of risk management techniques.

Most accidents are due to identifiable and predictable causes, not from uncontrollable circumstances. Let's continue to meet this year's challenge head-on by remembering that risk management is everyone's responsibility. So far, it shows and it's saving lives. And that's good news!

**NOTE: The statistical data reflects cumulative information beginning on 1 October through 31 March of each fiscal year.**

**—Mr. Ed Heffernan, Safety and Occupational Health Manager, US Army Safety Center, DSN 558-2970, (334) 255-2970, hefferne@safetycenter.army.mil**

# Risk Management—Shoulda, Coulda, Woulda

How many times have you heard someone say, "I should have done this" or "I could have done that", after they had done something else, or done nothing at all? Too often it's heard after an accident occurs. The same applied to the word "would." Before reality raises its ugly head to bite you, think a bit the next time you hear or say:

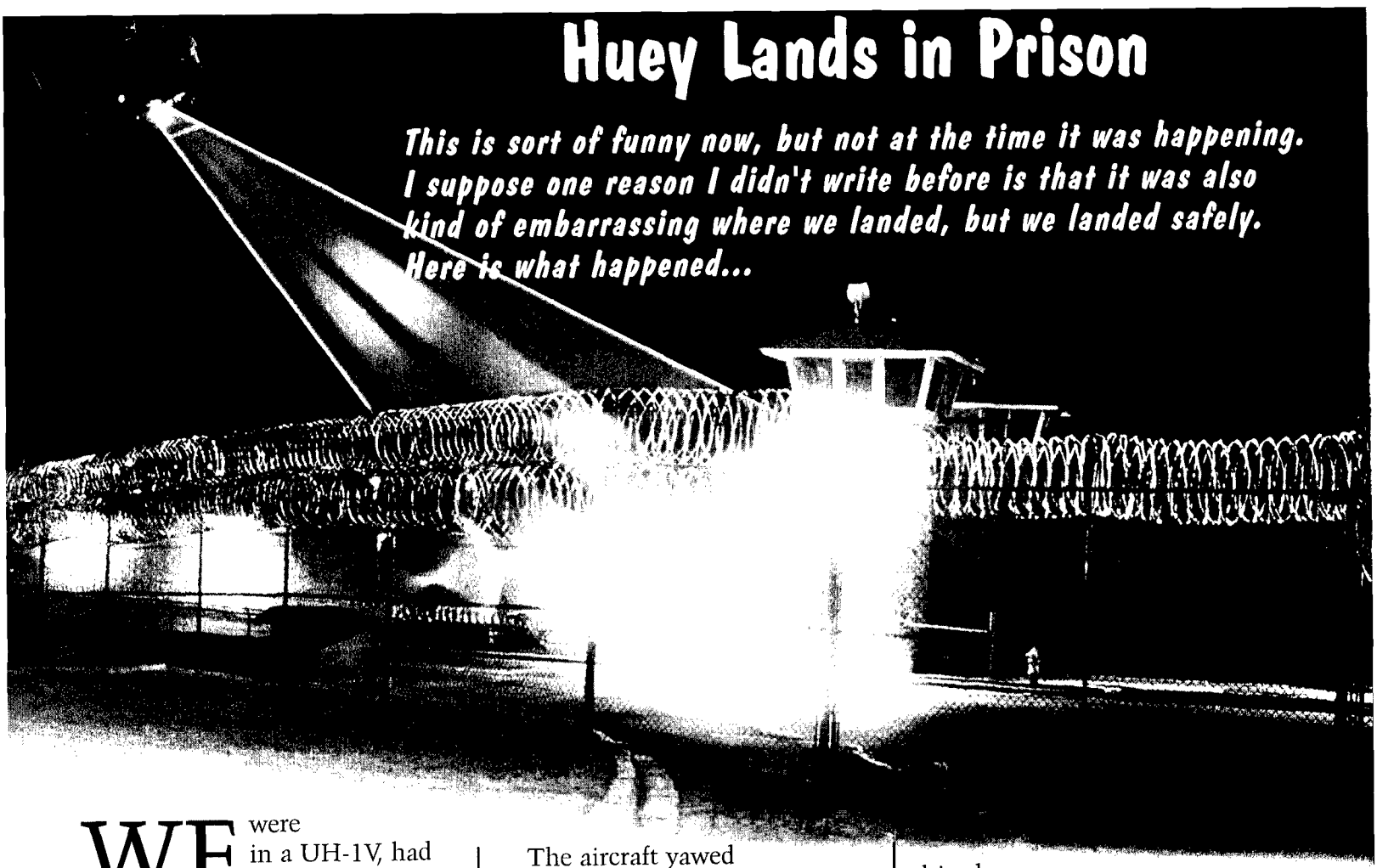
- I should have checked the weather more closely before I left.
- I should have taken a bit more time checking the condition and the rigging of the slingload.
- I could have cleared the trees coming out of that confined area if I'd had a bit more power.
- I would have planned the flight differently if the "head shed" hadn't put pressure on me to get the mission accomplished.
- I could have made it with a bit more fuel.
- I would have written up that anomaly, but we needed to complete the maintenance and get the aircraft up.
- I should have made sure my passengers were appropriately briefed.
- I should have spoken up when I realized the mission would extend well beyond my crew day.
- I should have known the dust would cause a brownout.
- I should have known that loose net would get airborne.
- I should have told him about the rotor blades.
- I would have worn my survival vest, but it was just a routine mission.
- I should have checked the survival radios.

Hindsight is great for lessons learned, but foresight is the key to accident prevention. Identifying hazards and developing and implementing controls to eliminate or reduce risks before and throughout the mission are the best ways to avoid lamenting what you coulda, shoulda, woulda, done, after the painful bite of an accident. Turn your coulda, shoulda, woulda statements into control measures, before an accident happens.

**—Concept courtesy of Aviation Safety Vortex**

# Huey Lands in Prison

***This is sort of funny now, but not at the time it was happening. I suppose one reason I didn't write before is that it was also kind of embarrassing where we landed, but we landed safely. Here is what happened...***



WE were in a UH-1V, had just dropped off a patient at Tripler Army Medical Center, and were en route back to Wheeler AAF. On board we had two pilots, one crew chief, one medic, and one civilian medical technician (the only one without a headset). It was about 2000 hours and we didn't fly with goggles. I was on the controls with another CW2 as the PC.

ATC cleared us for a H1 transition back to Wheeler and an altitude of 1500. As we turned from a small valley to H1 and climbed through 800 feet, I noticed the master caution light come on. The PC confirmed it was a chip light. I told the crew in the back to start looking for a suitable area to land while the PC contacted ATC. Just as the ATC asked if we were declaring an emergency, the panel lit up like a Christmas tree!

The aircraft yawed about three times to the left and right and lost about 200 to 300 feet in altitude. Bells were going off, and irregular sounds were heard from the engine. (I thought the engine noise was going quiet, while someone else thought it sounded like compressor stalls, and another thought it sounded like it was overspeeding.) More lights came on. I said, "We have more than a chip light now", and heard the PC answer ATC "Roger, we are declaring an emergency."

My first instinct told me we had an engine failure and that I should immediately start an autorotation. But something in the back of my mind said remember to confirm. I quickly looked at the gauges. No help there. Some of the gauges were flat lined (including the torque gauge).

I reduced the collective a little, and we were able to maintain the altitude with reduced power setting. Now I knew we had partial power.

I was trying to figure the best place to go. It was dark below us, but I could see an interstate highway. There was a large hill to the left that I wasn't even considering climbing over (it was also a military housing area.) Straight ahead were some high-tension wires about 400 feet high. Then to the right there was an industrial park. I had a brilliant thought; an industrial park equals large parking lots. So I thought. I stated I was turning right. Everyone cleared right and continued to look for a suitable area.

## A PLACE TO LAND

Though at a reduced power setting, we were still flying, but I knew time was running out. The PC announced "large field at 12 o'clock" about the same time I

saw it—a large field, brilliantly lit, about a mile ahead of us. I thought it was a baseball field and figured they were having a night game. As we got closer we could see power poles everywhere, except on the one large field in the center of what appeared to be a large surrounding complex of buildings and fences. I continued with my silent prayers for the engine to continue running as I began the approach, aiming for the center of the lit-up area.

When at about 50 to 75 feet above the surrounding buildings, I found myself looking into a guard tower on my left, I realized we were landing in a prison. We had a good approach angle and rate of descent going, and were committed to landing, prison or not. I was reluctant to move the collective if I could avoid it, so I used the cyclic to trade off airspeed for altitude until we cleared the last fence, when I reduced the collective and allowed the aircraft to settle to the ground. We had a ground run of about 20 feet.

As we did an emergency shutdown, the crew chief came on the radio saying, "I couldn't stop him." Apparently the civilian medic unfastened his seat belt and ran. We didn't have a chance to do anything about that. The crew concentrated on the aircraft. We grouped together at the side and for a few seconds stared at each other and the aircraft. There was some nervous laughter.

Meanwhile, the civilian ran to the guards and told them to call the fire department. He didn't know the aircraft dumps fuel upon shut down. When he smelled fuel, he thought we had a major fuel leak.

### CREW COORDINATION

When we all got together and talked, everything that happened was pieced together. The cooperation of the civilian authorities was outstanding. The fire department, police department, and the EMT supervisor were all on site within 15 minutes. Our battalion commander was also there within 20 minutes. He just happened to be walking into Tripler when he heard irregular sounds from the aircraft and saw it was one of his.

The next day, a CH-47 slingloaded the aircraft home. When the crew chief took the chip detector out, it was covered with metal. Our maintenance officer said, "I don't know what made you think of not increasing the collective, but if you had, the engine probably would have seized."

Though it seemed the time elapsed was about 15 to 20 minutes, it actually all happened in about 2 minutes. The crew worked as a team without being told what to do.

If there was one thing I could have done differently, it would have to be to ensure the civilian takes directions from the crew and knows what's happening. Every civilian medical technician is taught aircraft procedures, but most are not faced with flight emergencies. This incident taught me a few things:

a. Rely on your training.

b. Know where you are.

c. Crew coordination is important.

d. Things happen fast.

We never did find out what caused the problem. I am still curious.

**—Anonymous**


# Instructor Pilot Complacency

A dictionary defines complacency as "contented to a fault; self-satisfied and unconcerned." To a pilot, these traits are undesirable and could have deadly results. Yet, many accidents occur every year with the primary cause determined to be "pilot complacency."

As a Chinook instructor pilot (IP), I have the job of teaching and evaluating various procedures of helicopter operations. One of the more dangerous areas of instructing is emergency procedure training.

As a new instructor pilot, I was very cautious when I simulated an emergency procedure. One of the more dangerous of these is the simulated engine failure. This procedure is even more dangerous while utilizing night vision goggles (NVGs). Performing simulated engine failure, the IP retards the engine condition lever (throttle.) By doing so, he risks the possibility of the engine actually failing or the trainee/evaluee responding incorrectly. Therefore, it is imperative that the IP maintain a high level of awareness.

As time went on, my experience level and confidence as

an instructor pilot flourished. One night, I was assigned to fly with a pilot while using NVGs in order to start his NVG refresher training. The pilot had about 75 hours of flight time while using the NVGs, but hadn't flown with NVGs for two years. I knew the pilot well and I had progressed him to RL1 (readiness level). Furthermore, I had about 15 hours of flight-time with this particular pilot. I had begun the training with classes on the NVGs, and he was well prepared for the training. The next step was to hit the flight line.

## READY TO GO

After the daily ritual of pre-flight, flight planning, and checking weather, we were ready to go. It was a beautiful night—you could see every star and the moon was about 60% illuminated. Not a cloud in sight and the forecast was severe-clear!

We climbed in the cockpit and began the run-up process. Before long, we were beating the air into submission. For his first flight in 2 years, he was hovering very well. Soon, we took off from our base station and flew to a small airfield about 20 minutes away. I have done many NVG training flights at this small airfield. Although it was late and the tower had already closed, I had communication with crash/rescue, which is required by U.S. Army regulations prior to conducting emergency procedure training. So, after a couple of traffic patterns with no interference from the IP, I was ready to see how he could handle emergency procedures. Since he was doing so well, I would start off with a simulated single engine failure. After all, I had given him the same emergency procedure numerous times during the day and he had performed fine.

With the before-takeoff checks complete, the pilot increased the thrust and off we went. On the downwind leg of the traffic pattern at 700 feet, traffic pattern altitude, I initiated the emergency procedure by retarding the No. 2

**"The greatest of faults, I should say, is to be conscious of none."**

*—Thomas Carlyle*

engine condition lever to ground idle. The pilot called out the first step of the emergency procedure, "Thrust adjust." Normally, the thrust is usually reduced to regain rotor RPM. I was sitting back waiting for the completion of the procedure when I noticed the rotor RPM continued to decrease to a dangerous point, a point when the main generators would come off-line. I then looked over and noticed he had increased the thrust.

Before I knew it, the aircraft was going out of control. I then announced "I have the controls," but he became unresponsive and unwilling to relinquish the controls. I continued to increase the rotor RPM to within safe limits, but was ineffective due to the amount of thrust he had pulled. I noticed our climb rate increase to a rate of 2000 to 2500 feet per minute and the altimeter was rising rapidly. Again, I said, "I have the flight controls!" and still the pilot would not relinquish the controls.

## WHAT IS GOING ON?

The flight engineer, growing concerned, said, "What is going on?" as he felt the aircraft going out of control.

I looked outside the window and all I could see were stars, indicating we were now in a nose-high attitude. Suddenly, the pilot let go of the controls, and I reduced the thrust and regained control of the aircraft. After I established a level flight attitude, I noticed we had climbed from 700 to 3000 feet in what seemed to be a matter of seconds. The pilot asked, "What happened?" I recovered the engine and proceeded to land the aircraft.

Once on the ground, I explained to the crew what had happened. After we all got a chance to catch our breath, I demonstrated the simulated engine failure, discussed it in detail, and he performed another without error.

After the flight, I mentally went over the portion of the flight that will be forever etched in my memory. I was slow to react to a potentially fatal situation because I was complacent and was not expecting anything like what had happened. I had performed the procedure many times with this same pilot under a different flight mode, and he performed it flawlessly. I should not have taken such a lax position in the cockpit, knowing that the pilot at the flight controls was not familiar with this flight mode. After experiencing so many uneventful simulated emergency procedures, it took an alarming situation to reveal my complacent self. Thomas Carlyle, a Scottish essayist, said, "The greatest of faults, I should say, is to be conscious of none." This is true today, as it was when he wrote it in the 19th century. Finally, don't let a situation develop before you realize your complacency.

**—CW3 James K. Scala, 5th Bn, 158th Aviation Regiment, Box 478, APO AE 09182**

# Perishable Skill—Currency is Not Proficiency

Perishable skills. We have all heard the phrase, "That's a perishable skill", but what does it really mean? I have heard it for almost 20 years and always thought of my golf swing as my most "perishable skill." But a recent accident investigated by the Safety Center brought the phrase back to mind in a much more appropriate way.

This UH-60L accident serves as a prime example of how perishable some skills really are. It involved a crew that no one ever expected to have an accident.

The instructor pilot had over 8,000 hours of rotary-wing experience; the PI was young but highly thought of; and all the crew members had flown together many times in the past. Both aviators were qualified and current for the night vision goggle environmental training mission.

The problem? Neither crewmember had significant recent experience in NVG flight. The hostile conditions overcame their skills. They became disoriented during a takeoff and crashed, destroying the aircraft. Fortunately, everyone on board will fully recover from their injuries.

We are all aware of "NVG currency" requirements as stated in the Aircrew Training Manual (ATM) for each aircraft. Instructor pilots and unit commanders constantly monitor aviators to ensure that everyone remains current by flying at least one hour every 45 days under goggles. As long as we maintain that standard, we can report combat-ready goggle crews to the chain of command every month.

But, in the back of our minds, we all know that one flight every 45 days does not maintain the proficiency necessary to execute the tough missions we may be called upon to complete. This mission is a perfect example.

**If any one of the conditions—low recent experience, dust, winds, or low illumination—had not been present, perhaps the accident would not have occurred.**

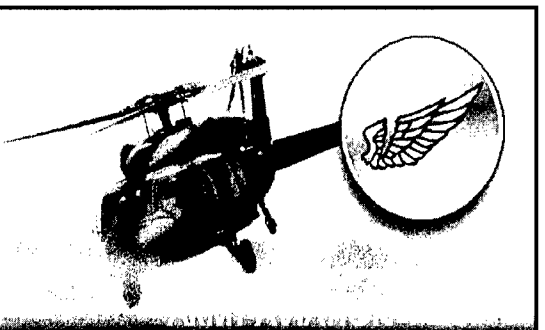
**If, If, If...**

The aviators involved in this accident were NVG current. They met the ATM standards required to conduct the mission. However, neither crewmember had flown more than 3 hours of NVG flight in a single month for over 7 months. We have all seen this in our units at one time or another. Other mission requirements, administrative obstacles, or flight time restrictions have put nearly everyone in this position at some time. Most often we manage to get the mission accomplished when called on. The problems arise when an aviator who is just maintaining currency is placed in conditions with which he is unfamiliar and that require real proficiency rather than currency.

In this case, we put these aviators in a dusty, windy environment, with low illumination, with little recent experience under NVGs, and all these things added up to a situation primed for an accident. The cumulative effect of the risks associated with this mission exceeded the capability of the crew, and a major accident was the result. If any one of the conditions—low recent experience, dust, winds, or low illumination—had not been present, perhaps the accident would not have occurred. If the aircrew had more recent experience, they would have been better able to deal with the harsh environment. If the illumination had been better, their low recent experience might not have been a factor. If the conditions had not been as dusty, perhaps the crew would not have become disoriented. If, If, If...

The key lesson to be learned is that there are perishable skills. Night vision goggle flight is one of the most perishable skills in our business. When circumstances force us to maintain NVG currency rather than proficiency, we must be aware that those aviators are not ready to proceed directly into harsh environments. Commanders must transition through the crawl, walk, run scenario. NVG currency is the crawl. NVGs in adverse conditions, such as the desert or other severe environments, are Olympic events. We can't expect aircrews to go straight from one to the other.

**—LTC W.R. McInnis, Chief, Operations Division, US Army Safety Center, DSN 558-2194, (334) 255-2194, mcinnisw@safetycenter.army.mil**



BROKEN WING AWARD

BROKEN WING

# Broken Wing Award Requirements

*AR 672-74, Army Accident Prevention Awards Program, outlines the requirements for a Broken Wing Award.*

To be eligible for the award, an aircrewmember must, through outstanding airmanship, minimize or prevent aircraft damage or injury to personnel during an emergency situation.

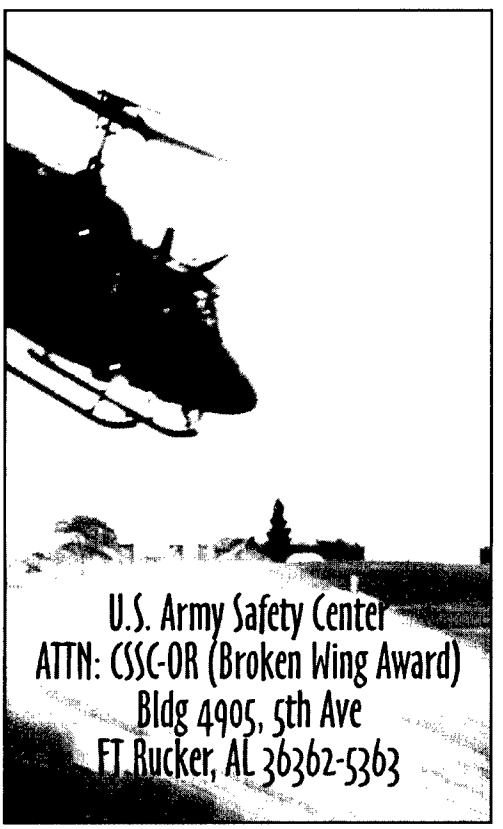
An emergency will not be considered for an award if-

- It is self-induced.
- It actually occurs during a simulated emergency requiring no skill to land the aircraft successfully.
- It occurs because of non-compliance with published regulations or procedures.
- It is determined that no emergency actually existed.
- A lack of discipline or aviator judgment may have induced the emergency.
- The aircraft was in a phase of flight with no unfavorable circumstances to prevent a safe landing.

## Nomination Requirements

Nominations must include the following information:

- Full name, SSN, and crew duty of the person actually on the controls during an emergency.
- Date, time and location of the emergency.
- Mission type, design, and series of the aircraft involved.
- Type of mission.
- Phase of flight when the emergency occurred.
- Kind of terrain over which the emergency occurred.
- Obstructions, dimensions, type and condition of the landing area.
- Altitude above ground level.
- Density altitude.
- Wind condition (direction and velocity).
- Gross weight of the aircraft when landing.
- Concise description of the emergency from inception to termination.
- Action taken by the nominee to cope with the emergency and what was done to recover from the emergency or minimize damage or injury. The circumstances surrounding the occurrence must be documented to show the skill, knowledge, judgment, and technique required and used in recovering from the emergency.
- Lapsed time from onset of the emergency to termination.
- Drawings, other supporting documentation, if available.
- Copy of the abbreviated aviation accident report (AAAR) if required and submitted.




## Submitting Nominations

The unit commander or installation or unit safety manager should initiate nominations for the Broken Wing Award. Normally, only one person will be nominated to receive the award for a single in-flight emergency. However, if more than one crewmember materially contributed to successful recovery from the emergency, all those involved should be considered for nomination.

Nominations for the Army Aviation Broken Wing Award should be forwarded through command channels to the US Army Safety Center, ATTN: CSSC-OR (Broken Wing Award), Building 4905 (Fifth Avenue) Fort Rucker, AL 36362-5363.

## Nominating Evaluations

A panel consisting of the Director of Army Safety, or his representative, and at least five aviators will review the nominations. The panel may include senior enlisted crewmembers when appropriate. At least one panel member will be qualified in the mission type and design of the aircraft involved in the emergency.

—Mr. Dick Lovely, US Army Safety Center, DSN 558-1235, (334) 255-1235, lovelyr@safetycenter.army.mil

# NCO Corner
# "It Could Have Been Me!"

After being at the Safety Center almost 2 years, I've had enough time to get used to the questions about the patch above my right pocket and then the almost inevitable, "Safety Center? What's that?" To tell the truth, when I got the phone call to come here, I had the same reaction: "The Army Safety Center? What in the world is that?"

Of course, I knew all about safety. After all, I'd heard about it my whole career. Units had safety officers and NCOs put up safety posters on the bulletin boards. They would check the fire extinguishers to make sure they were up to date. Safety people were harmless enough, really. But that post safety officer! His mission seemed to be to make my life as miserable as possible. If he wasn't coming around doing a safety inspection, he was telling me why I couldn't get a mission done the way I wanted because it wouldn't be safe. What was his problem anyway? The Army is a risky business. If we aren't willing to accept a little risk, what are we doing in the Army? Sure, now and then someone is going to get hurt, but isn't that the cost of doing business?

Since reporting to the Safety Center, I have changed my mind. The Safety Center has a good system for processing and computerizing accident data. All the cold, official language of accident reports eventually ends up stored for easy access in an efficient computer database. Everything gets so well categorized that it sometimes seems that the Army could determine in a few minutes how many soldiers got hurt last year tripping over cracks in the sidewalk while wearing Santa Claus suits. At first, this all looked to me like one more bureaucratic waste of money.

Then one day, I had to retrieve data on cold weather-related accidents and injuries for a Countermeasure article. Naively, I decided to look at several years in order to get enough information to establish any trends. I ended up with an overwhelming pile of computer printouts covering cold-weather injuries, cold-weather vehicle accidents, tent fires, and all the other ways in which soldiers manage to hurt themselves when the cold season comes around each year.

Laboriously, I sifted through the reports, and I began to understand several things. First, the cost of these accidents was greater than I had ever imagined, whether measured in purely economic terms or in human costs. Secondly, almost all the accidents could have been prevented if someone had followed proper procedures, used a little common sense, or taken a little more care. More often than not, there was an NCO or officer who could have acted to prevent the accident. Finally, there were similarities. After a while, I could read a few lines of a report and almost predict the outcome.

Before I could get too self-righteous in dismissing all these soldiers and their NCOs as the victims of their own lack of good judgment, I realized uneasily that, in too many cases, I was seeing myself. I had done many of the same things they had. The difference was that I was lucky and got away with it. Obviously, I had not recognized the odds against me when I trusted the welfare of my soldiers as well as myself to blind luck. It wasn't long before I noticed the same similarities in other kinds of accidents.

"I had done many of the same things they had. The difference was that I was lucky and got away with it."

Being a soldier is riskier than being a civilian. There is nothing glamorous or macho or professional about being hurt or killed in an accident, on or off duty. I have pledged that I will never again accept risk blindly. From now on, I want to know ahead of time what the risks of an operation are—whether conducting a water-crossing or mowing grass at home. When I can eliminate a hazard and still get the mission accomplished, I will. I will try to minimize the risks that I can't eliminate, and I will do my best to ensure that those around me do the same.

**POC: SFC Michael R. Williams, Ground Systems and Accident Investigation Division, USASC, DSN 558-2959 (334)255-2959, williamm@safetycenter.army.mil**

# Shortfax
Keeping you up to date

## Warm Days Ahead—Secure Your Gear

Several years ago I recall that a UH-1H had taken off in a flight of five aircraft, somewhere in the Ft Campbell, KY training area, with the cargo doors open. It was really beginning to get warm, and nothing beats nature's air-conditioning. The deal in those days was to carry your steel pot, LBE and other paraphernalia with you in the aircraft.

It just so happens that this was a beautiful warm spring day, when you wished you were teeing off on the local golf course instead of...

On take off at about 500 feet, while just entering cruise flight, a poncho became loose in the passenger compartment and flew out the door. The poncho became tangled in the tail rotor, and the aircraft crashed. Unfortunately, there were several fatalities.

Let's ensure that while reading your checklist you mean what you say. When it comes to "Crew, passengers, and mission equipment—Check", it should mean just that. All rotors like clean air and no FOD! It could save your life.

—Robert Giffin, Systems Manager, Utility Branch, US Army Safety Center, DSN 558-3650 (334) 255-3650 giffinr@safetycenter.army.mil

## Aviation Safety NCO Training

You may have noticed in the new AR 385-95, *Army Aviation Accident Prevention*, dated 10 December 1999, that the aviation safety NCO is no longer required to possess the additional skill identifier (ASI) A2. It does require the NCO to be safety-trained and appointed by the unit commander, in writing, to assist the aviation safety officer.

There are numerous ways for a safety NCO to get trained. The standard for aviation safety NCO training is successful completion of the Aviation Accident Prevention Course, or the NCO Safety and Risk Management Professional Development Course, offered by The Army Safety Center, or NCO Academy training. Existing local installation or MACOM training programs meet the requirements for training aviation safety NCOs.

In October 1999, The Army Safety Center implemented the NCO Safety and Risk Management Professional Development Course. During the last several months, nearly 700 NCOs and officers have received this training.

The Fort Rucker NCO Academy will instruct four NCO Safety and Risk Management Professional Development courses this fiscal year at the BNCOC level. The long-term benefit of this initiative will be safety training for all CMF 67 and 93 BNCOC graduates.

The Aviation Accident Prevention Course is taught by several certified vendors. A listing of these vendors is on our homepage. For NCO safety and risk management professional development course scheduling, or certified vendor information, go to the USASC public web site, http://safety.army.mil

—CW5 Butch Wootten, Director, Aviation Safety Officer Course, DSN 558-2376 (334) 255-2376 woottend@safetycenter.army.mil

## Website Sources of Help

■ The NEW Petroleum website is
http://www.quartermaster.army.mil/pwd
If you only wish to reach the Quartermaster Center and School, drop the "pwd".

■ For additional assistance pertaining to Petroleum And Water Systems (PAWS), there is a Help Desk. Their phone number is commercial (810) 574-4143/4229 or DSN 786-4143/4229. Their web address is: http://www.tacom.army.mil.

■ To obtain AMC/TACOM equipment Safety of Use Messages, Maintenance Advisory Messages
http://aeps.ria.army.mil/aepspublic.cfm

■ The AMCOM Safety Office's web page is:
http://www.redstone.army.mil/safety/home.html

—Jim Lupori, US Army Petroleum Center , DSN 977-6445, (717) 770-6445 jlupori@usapc-emh1.army.mil

# Accident briefs

**Information based on *preliminary* reports of aircraft accidents**

## AH64

### Class E
#### A series

■ During engine run-up, as power levers were moved forward to Fly, the No. 1 and No. 2 generators dropped off line simultaneously. Generator No. 1 would not reset. Generator No. 2 momentarily reset and then shutdown. Power was brought back to idle, APU started and both generators were reset successfully. SDC light would not extinguish, so flight was aborted. Cause of generator failure was not determined.

■ During cruise flight, the CPG master caution light and No. 1 engine caution light flickered on and off. Aircraft landed without further incident.

■ During post-flight inspection, crew noted excessive oil residue on No. 1 generator. Maintenance personnel determined that the seal between the generator and accessory gearbox had failed. The seal was replaced. Aircraft maintenance operational system checked out and aircraft was returned to service.

#### D series

■ During cruise flight, the crew received the Manual Stabilator Advisory along with a slight forward pitch in attitude. Shortly after-ward, multiple instrument failures and warning lights were noted. Upon landing the #2 generator took over all loads. Maintenance discovered that the spline adapter had failed and replaced the spline adapters with modifications directed from manufacturer. Aircraft was released for flight.

■ During cruise flight the crew received voice warning of BUCS failure and FMC channel disengagement. The No. 2 generator failed. During the approach to an open field, the No. 1 generator failed. All four MPD's went blank, there was no symbology on the HDU's, and the UFD continued to operate normally until the battery died approximately 7 minutes later. Maintenance replaced the spine adapters on both generators with the modifications directed from manufacturer. The aircraft was released for flight.

■ While advancing the power levers to fly during engine run-up, the No. 2 engine overspeed voice warning was announced and the No. 2 engine overspeed was displayed on the UFD. The No. 2 engine overspeed warning was displayed on the DMS warning page and NP overspeed was written on the exceedance page. Crew completed a normal shutdown with normal indications on the engine page and notified maintenance. Maintenance discovered that the No. 1 system processor was causing erroneous information to be sent to the data management system. Maintenance replaced system processor and released aircraft for flight.

■ Navigation lights failed during aircraft run-up, prior to night system training flight. Circuit breaker on HPSM popped and was reset. Circuit breaker popped 5 seconds after turning lights on. Mission was aborted. Aircraft shut down without further incident. Maintenance inspectors revealed the tail navigation light's filament had folded over inside the bulb, causing the circuit breaker to pop. The light bulb was replaced and the aircraft returned to flight.

## CH47

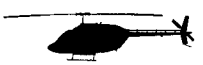
### Class C
#### D series

■ During maintenance test flight, right side pilot's door came off, striking the blade and aft pylon.

### Class E
#### D series

■ While hovering over slingload, aircraft No. 1 engine RPM rapidly climbed to 110%, and No. 1 torque climbed to 120%, with a decrease in No. 2 engine torque to 25%. IP on the controls recognized the N2 Governor failure, and through application of thrust and manual manipulation of the engine condition lever, brought the No. 1 engine RPM back into normal range within 5-10 seconds. Aircraft was returned to the airfield, and maintenance replaced N2 Actuator.

## OH58



### Class C
#### Series D (R)

■ During simulated engine failure at altitude, engine torque peaked to 133% for 1 sec.

## UH60

### Class C
#### A series

■ Suspected tree strike during landing to a dusty LZ in brownout conditions. All 4 main rotor tip caps revealed damage.

■ Aircraft main rotor system contacted a tree during masking/unmasking scenario. Aircraft was landed and shut down without further incident. Damage to three main rotor blade tip caps and two blades.

**For more information on selected accident briefs, call DSN 558-9855 (334-255-9855). Note: Information published in this section is based on *preliminary* mishap reports submitted by units and is subject to change.**

## Memorial day Concert

**This year's National Memorial Day Concert, telecast on PBS, will feature a special segment commemorating the 50th anniversary of the Korean War, plus tributes to all Americans who fought in the wars of the 20th century.**

**A blend of musical performances, archival footage and dramatic readings, the concert will be broadcast overseas by the Armed Forces Radio and Television Service. It will air on public television stations nationwide at 2000 hours, 28 May.**

# 1999 Quad A Awards

*Congratulations to the 1999 Army Aviation Association of America national award winners.*

### Outstanding Aviation Unit of the Year (Active):

2nd Battalion, 227th Aviation Regiment, 4th Brigade (Aviation), 1st Cavalry Division, Fort Hood, TX 76544. LTC Donald M. MacWillie III, commander; CSM Jimmy G. Ruiz, senior NCO.

### Outstanding Aviation Unit of the Year (ARNG):

24th Medical Company (Air Ambulance), 2400 NW 24th Street, Lincoln, NE 68524. MAJ Scott A. Gronewold, previous commander; 1SG Troy Johnson, senior NCO.

### Outstanding Aviation Unit of the Year (USAR):

8th Battalion, 229th Aviation Regiment (Attack), Operation Joint Forge, Comanche Base, Bosnia APO AE 09789/Fort Knox, KY 40121. LTC John E. Valentine, commander; CSM James H. Robinson, senior NCO.

### Robert M. Leich Award:

US Army Scout-Attack Helicopter Product office and predecessors, US Army Aviation and Missile Command, Redstone Arsenal, AL 35898. LTC William M. Gavora, product manager; Mr. John Guenther, deputy product manager.

### Army Aviator of the Year:

CW3 Daniel R. Zimmermann, A troop, 2nd Squadron, 6th Cavalry, 11th Aviation Regiment, APO AE 09140

### Aviation Soldier of the Year:

SFC William G. Sikes III, D Company, 1/260th SOAR (A), Fort Campbell, KY 42223

### Joseph P. Cribbins Department of the Army Civilian of the Year:

Ms. Gerri Shelp, 21st Cavalry Brigade (AC), Fort Hood, TX 76548

### James H. McClellan Aviation Safety Award:

CW4 Greg S. Schneider, HHC, 5-158th Aviation, APO AE 09182

### Top Chapter of the Year:

AAAA Tennessee Valley Chapter, BG(P) Joseph L. Bergantz, Chapter president, Redstone Arsenal, AL 35808

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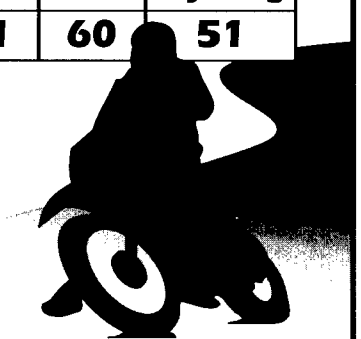
## POV Fatalities through 31Mar

| FY00 | FY99 | 3-yr Avg |
|---|---|---|
| 51 | 60 | 51 |

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